



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

MEMORIAL HERMANN HOSPITAL SYSTEM  
C/O SULLINS JOHNSTON ROHRBACH & MAGERS  
3200 SOUTHWEST FWY STE 2200  
HOUSTON TX 77027-7533

#### **Respondent Name**

ZURICH AMERICAN INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-07-2181-01

#### **MFDR Date Received**

November 15, 2006

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Memorial Hermann Hospital is a non-profit teaching hospital, and operates a class I level trauma and burn center with Life Flight services. Memorial Hermann Hospital typically receives the most severely injured persons from industrial accidents, auto accidents and other accidental injuries. It has one of the finest hospital staffs for handling major trauma and burns. Memorial Hermann should receive higher reimbursement rates for trauma and burn cases due to the unforeseen level of treatment and care necessary for major trauma and burn victims, for providing a well trained staff capable of handling major trauma and burns, and for providing the plant, facilities and services available to provide that level of care. It is the hospital's position that a unilateral reduction of its usual and customary charges by 96% is inherently unfair and unacceptable from a commercial insurance company. . . . Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred since the carrier refused to conduct an audit to refute those charges. Requestor is owed an additional \$26,414.25, plus interest."

**Amount in Dispute:** \$26,414.25

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The services were paid based upon a surgical admission under the Acute Care Inpatient Hospital Fee Guideline per diem method as a measure of fair and reasonable. Note that while this is coded as a trauma admission, the patient was injured . . . some three weeks prior to the admission. This is a surgical admission by any standards and should be reimbursed as such."

**Response Submitted by:** Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 17, 2005 to November 18, 2005	Inpatient Services	\$26,414.25	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on November 15, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 29, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
  - 226 – INCLUDED IN GLOBAL CHARGE.
  - 253 – IN ORDER TO REVIEW THIS CHARGES WE WILL NEED A COPY OF THE INVOICE.
  - 42 – CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT.
  - 790 – THIS CHARGE WAS REDUCED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
  - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
  - 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
  - 793 – REDUCTION DUE TO PPO CONTRACT.

## **Findings**

1. The insurance carrier reduced or denied disputed services with reason code 45 – “CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT” and 793 – “REDUCTION DUE TO PPO CONTRACT.” Review of the submitted information found no documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute or with a participating provider network. Nevertheless, on June 1, 2012, the Division requested the respondent to provide a copy of the referenced contract between Zurich American Insurance Company and the alleged network, as well as a copy of the contract between the network and Memorial Hermann Hospital System, pursuant to former 28 Texas Administrative Code §133.307(l), effective January 1, 2003, 27 *Texas Register* 12282, which states that “The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request.” On June 18, 2012, attorneys Flahive, Ogden & Latson responded on behalf of the respondent by facsimile transmission which stated that “It has been determined that there is no provider contract applicable to the DOS at issue.” The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5), which requires that “When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate: (A) Trauma (ICD-9 codes 800.0-959.50); (B) Burns (ICD-9 codes 940-949.9); and (C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042-044.9).” Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 825.25. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047 requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:

- The requestor's position statement asserts that "Memorial Hermann should receive higher reimbursement rates for trauma and burn cases due to the unforeseen level of treatment and care necessary for major trauma and burn victims, for providing a well trained staff capable of handling major trauma and burns, and for providing the plant, facilities and services available to provide that level of care. . . . Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred since the carrier refused to conduct an audit to refute those charges."
- The requestor did not submit documentation to support that Memorial Hermann should receive higher reimbursement rates for trauma and burn cases.
- The requestor did not submit documentation to support the level of treatment and care necessary for major trauma and burn victims, or of the cost of providing staff, physical facilities, and services available to provide that level of care. Nor did the requestor submit documentation to support a comparison of the costs and level of care required for trauma and burn victims as compared to the costs and level of care required for other types of hospital admissions.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges..." 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The Division has previously found that a reimbursement methodology based on hospital costs does not produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 that:

"The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models... are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs... Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs."

Therefore, a reimbursement amount that is calculated based upon a hospital's costs cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

## **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### Authorized Signature

_____	Grayson Richardson	December 27, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**